

Why Don't People Change? A Psychoanalytic Perspective

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From a psychoanalytic perspective, a central reason that people do not easily change is their fear of the dangers that they believe, at some level, change entails. These dangers include relinquishment of infantile wishes and fantasies, anxiety that would be experienced were defenses weakened, guilt, fantasies that change would harm a parental figure or threaten a vital relationship. Other factors that prevent change and maintain the sameness of behavior include defenses, unconscious pathogenic beliefs, devotion and loyalty to early figures, stable internal working models of self, other, and prototypic interactions, and emitting cues that elicit responses from others that confirm these working models. Finally, I discuss some selective psychoanalytic research on therapeutic change.

KEY WORDS: therapeutic change; fear; anxiety; guilt; defenses; pathogenic beliefs; self–other interactions; psychoanalytic research.

INTRODUCTION

This paper deals with a psychoanalytic perspective on the question of why people don't change and, like all perspectives, is a limited one. It is unlikely that a psychoanalytic perspective alone can adequately address the general question of why people don't change, when change is understood to refer to a wide range of behaviors, from smoking to voting behavior, from work habits to value systems. The psychoanalytic perspective focuses on a particular context for the question. That context includes the treatment situation and neurotic symptoms and maladaptive behavior patterns that

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persist despite the distress they entail. Hence, from a psychoanalytic perspective, the question of why people don't change generally can be reduced to two more specific questions: (1) Why do maladaptive and neurotic symptoms and behavior patterns persist despite the obvious pain with which they are associated? (2) Why don't people readily give up these maladaptive symptoms and behavior patterns in treatment—that is, why don't they change even when they seem to be motivated to change and, indeed, have taken the step of seeking help?

There are two general and not uniquely psychoanalytic reasons that people don't change, or at least don't change easily. One is fear of the unknown. As immortalized in Hamlet's observation, the unknown "makes us rather bear those ills we have than fly to others we know not of." The second is that change, particularly radical change, threatens one with loss of identity.

The distinctively psychoanalytic answers to the question of why people don't change are, I believe, variations of the above reasons. It seems to me that common to all variants and "schools" of psychoanalytic theory is the foundational assumption that people avoid change and continue to pursue even maladaptive behavior because at some deep level, they fear that changing their behavior will expose them to greater distress and danger than they are now experiencing. Although each variant of psychoanalytic theory discussed in this paper—Freudian theory, object relations theory, the control mastery theory of Weiss and Sampson, and attachment-relational theory³—has a somewhat different conception of the psychic dangers that may confront an individual, they are unified in the common, even if often implicit, assumption that the major obstacles to change lie in the individual's fears regarding the danger that change entails. I will also try to show that, common to all the psychoanalytic schools discussed in this paper, is the assumption that at a deep level people fear change because it represents a threat to the integrity of the self. Thus, from a psychoanalytic perspective, lack of change is not simply an obstacle to be overcome or bypassed through, for example, behavioral prescriptions. Rather, working with the patient's fear of and resistance to change—the conflicts, wishes, anxieties, and defenses in which the resistance is embedded—takes up a major part of psychoanalytically oriented psychotherapy.

WHAT IS CHANGE IN PSYCHOANALYTIC THEORY?

Before discussing various psychoanalytic theories of resistance to change, I want to note that there is an enormous range of the kinds of

³There are other psychoanalytic "schools"—for example, Kohut's (1984) self psychology, Kernberg's (e.g., 1976) formulations, and the so-called neo-Freudians—that I will not discuss in this paper.

change that are discussed in the psychoanalytic literature. Further, there is often no clear-cut distinction between what can be called outcome changes or goals (i.e., lasting changes one hopes treatment will achieve) and what can be called process changes and goals (Rice, personal communication; i.e., those changes that are presumably instrumental in bringing about one's outcome goals). For example, although one would normally think of the achievement of insight as a process goal that is instrumental in bringing about conflict resolution and symptoms amelioration, it can also be understood as an outcome goal in the sense that one hopes that increased self-understanding will be a permanent outcome of treatment.

Below are only some of the outcome and process goals that one encounters in the psychoanalytic literature. There is some overlap among them and I have made no attempt to distinguish process goals from outcome goals. Also, I have not indicated any source for these goals that are widely accepted in traditional psychoanalytic theory, but have done so in relation to those goals that are specifically associated with a particular theorist.

1. Resolution of unconscious conflict.
2. Renunciation of infantile wishes.
3. Less anxiety and guilt.
4. Amelioration of specific symptoms and target complaints.
5. Greater insight and self-awareness.
6. Strengthening of ego functions, including a greater sense of autonomy and choice and increased tolerance of anxiety.
7. Greater capacity to experience satisfaction and pleasure, including sexual satisfaction and pleasure.
8. Greater capacity for satisfaction from relationships, particularly intimate relationships.
9. Greater effectiveness in and satisfaction from work.
10. Greater capacity to cope adaptively with future difficulties and stresses (indicating that significant "structural changes" have occurred).
11. Softening of the harshness and punitiveness of the superego (Strachey, 1934).
12. Increase in self-cohesiveness (Kohut, 1984).
13. Greater ability to carry out one's "nuclear program" (Kohut, 1984).
14. "Exorcism" of the internalized "bad object and replacement of a "bad object" situation with a "good object" situation (Fairbairn, 1952).
15. Replacement of a "false self" with a "true self" (Winnicott, 1965).
16. Repeated "working through" of one's insights so that they become increasingly assimilated into one's ego structure.

17. Applying one's understanding and insights in the real world and expressing them in action (Schlesinger, 1982).
18. Relinquishing unconscious pathogenic beliefs (Weiss and Sampson, 1986).
19. Deepening of experience, including increase in range and depth of affects experienced.
20. Greater range of interests.
21. Increased capacity for self-observation.

It is likely that what is meant by change in psychoanalytic theory will be different from what is meant by change in other theoretical perspectives. Also, one must keep in mind that in discussing resistance to change, some of the above kinds of change are emphasized and others are deemphasized.

Freudian Theory

Although Freud discussed many different kinds and sources of resistance to change, his theory suggests two fundamental reasons that change is difficult. One has to do with the relentless pressure of instinctual drives for gratification, and the other with the use of repression and other defenses as means of avoiding anxiety. Both represent instances of the abiding operation of the pleasure principle.

According to Freudian theory, a basic reason that people persist in repetitive behavior, even when it is maladaptive, is that our behavior is motivated to a significant extent by the push to gratify infantile instinctual wishes. Because the instinctual drives to which these wishes are linked are an intrinsic part of our biological nature, these wishes persist over time and exert a constant motivational pressure on behavior both within and outside of treatment (see Rubinstein, 1976). Within the treatment situation, the patient's attempts to gain gratification of these wishes from the therapist—and the enactment of the conflicts, anxieties, and defenses surrounding them—constitute the *transference*.

Because many of the wishes one unconsciously attempts to gratify are inappropriate for an adult, and because from an early period on they have been associated with disapproval and anxiety,⁴ they are repressed, that is, banished from conscious awareness. The existence of repression then serves as an additional factor in preventing change and maintaining the sameness of behavior. It does so because as long as one's wishes and desires are unconscious, one cannot take active steps to either attempt to gratify them

⁴According to Freud (1926), certain wishes are associated with the "danger situations" of loss of the object, loss of the object's love, castration anxiety, and superego condemnation.

in reality or learn to live a satisfying life without their fulfillment. Either course is more adaptive than the alternative of partial and disguised gratification of repressed wishes through the formation of neurotic symptoms.

Thus, both the repression and continued (albeit disguised) pursuit of infantile wishes constitute resistance against change. Taken together, they result in the patient's tendency to repeat rather than remember (Freud, 1914, p. 150, and 1920, p. 18). Dewald (1982) refers to repression and the concomitant reluctance to become aware of one's unconscious wishes and conflicts as "tactical" resistance to be distinguished from the resistance to giving up the hope of gratifying one's infantile wishes, which he refers to as "strategic" resistance. According to Dewald (1982), in strategic resistance the patient seeks "fulfillment of infantile and childhood wishes . . . and/or the fantasies by which these are experienced and expressed. These strategic resistances include the [person's] reluctance to give up attempts to relive the past and to experience previously gratifying or unfulfilled satisfaction, and/or relationships; and the [person's] reluctance to accept in the present what is age-appropriate and realistically possible, rather than the impossible, no longer appropriate, and outmoded satisfactions and relationships" (p. 49).

In the treatment situation, the patient's transference reactions represent the clearest expression of "strategic" resistances. The very development of transference betokens the patient's fantasy that his or her infantile wishes will be gratified by the therapist. The patient unconsciously harbors the fantasy that the therapist will gratify his or her unconscious wishes, and is reluctant to give up this fantasy. The patient unconsciously prefers to "enact" the fantasy rather than become aware of it, and thus to change.

Thus, according to Freudian theory, a basic reason that people don't change (both in and outside of treatment) is the continued pursuit of outmoded satisfactions and the resistance to becoming aware of the very wishes they are pursuing. Both factors—the pursuit of wishes and the reluctance to become aware of them—are manifestations of the operation of the *pleasure principle*. Repression operates in accord with the pleasure principle insofar as the basic motive underlying one's reluctance to become aware of one's wishes and conflicts is avoidance of the anxiety that such awareness would entail.

Hence, a dilemma faced by the individual is that both the pursuit and repression of instinctual wishes operate according to the pleasure principle. Further, although the repression of instinctual wishes may succeed in banishing instinctual ideas from consciousness and thereby avoid anxiety, instinctual wishes continue to press for discharge. They are not eliminated by repression—they are merely removed from awareness. Some forms of discharge must be found lest the individual be faced with what for Freud

is the ultimate danger: namely, of being overwhelmed with excessive excitation. That is, some forms of behavior must be found that both permit adequate discharge and yet do not elicit traumatic anxiety.

One can see that neurotic symptoms and neurotic patterns of behavior represent attempts to resolve a seemingly intractable dilemma: to fail to gratify instinctual wishes entails the danger of being overwhelmed by excessive excitation and to attempt to gratify instinctual wishes openly (that is, to fail to repress them) risks eliciting intense anxiety, which also entails the danger of being overwhelmed by excessive excitation. However distressing neurotic symptoms and neurotic patterns may be, they are deemed, at some level, as preferable to the dangers entailed in the available alternatives. Thus, in Freudian theory resistance to change occurs because the symptoms or patterns of behavior to be changed are serving the vital functions of permitting partial gratification and, at the same time, avoiding intense anxiety.

My discussion above has been cast in the highly abstract language of Freudian metapsychology in which concepts such as excessive excitation are prominent. What is the relation between this level of discourse and people's desires, fears, aims, and so on? For example, what is the relation between talk of avoiding excessive excitation and Dewald's (1982) discussion of patients seeking fulfillment of childhood wishes, attempting to relive the past and to gratify unfulfilled satisfactions, and to pursue outmoded satisfactions? I believe the two perspectives are congruent. For the clinical counterpart to talk about an organism avoiding excessive excitation is a person pursuing infantile gratifications because to do so it is at some level experienced as involving less distress than the alternative of relinquishing these gratifications.

People who pursue infantile wishes and "outmoded satisfactions" usually do so because at some deep level they are convinced that only if these wishes are gratified and these satisfactions achieved is life really worth living. Even the illusion or the hope that these wishes can be satisfied and these satisfactions achieved will make life more tolerable. Indeed, as Waelder (1960) notes, in successful treatment patients often go through a period of mourning when they are finally able to relinquish these illusions and hopes. My basic point here is that at the abstract level of metapsychology and the clinical theory of psychoanalysis, one can say that the individual resists change because of his or her fear that such change entails even greater danger and distress than is currently being experienced.

When resistance is understood in this way, it becomes apparent that resistance is not to therapeutic change per se, but rather to experiencing painful feelings. Of course, an assumption of the psychoanalytic theory of treatment is that a reluctance to bring certain material to conscious aware-

ness impedes therapeutic progress. But the wish or intention to impede therapeutic progress is not necessarily a central aspect of the patient's motivation. Rather, the motive is the avoidance of painful experiences.

Repetition Compulsion

Up to this point, I have been discussing resistances to change that are motivated by the pleasure principle, that is, by the aim of avoiding pain—either the pain of experiencing anxiety were the repression to be lifted, or the pain of relinquishing one's early wishes and fantasies. Such resistances can be manifested in repetitive, unchanging behavior. There is a kind of repetition, however, that according to Freud (1920), cannot be explained by appeal to the pleasure principle, but that is, to use Freud's (1920) phrase, "beyond the pleasure principle." In his major work, *Beyond the Pleasure Principle*, Freud (1920) speculatively accounts for repetition and an earlier noted "psychical inertia" (Freud, 1915, p. 272) by positing an "urge inherent in organic life to restore an earlier state of things . . ." (p. 36) that is more basic and primitive than the pleasure principle. According to Freud, people keep repeating patterns of behavior that bring them great distress and, as far as one can tell, little, if any, pleasure. "We shall find courage to assume that there really does exist in the mind a compulsion to repeat which overrides the pleasure principle" (Freud, 1920, p. 22).

To attempt to account for repetition, however, by invoking a compulsion to repeat hardly constitutes an adequate explanation. And surely, at some level, Freud must have been aware of this. If, however, the compulsion to repeat could be embedded in a universal principle that governed all organic life, then repetition, along with a wide range of other behaviors, could yield to an explanatory account and could be seen as lawful. And, of course, as is well known, the universal principle or force that, according to Freud, was even more fundamental than the pleasure principle was the death instinct or *thanatos*. Freud's attempt to account for the compulsion to repeat through the death instinct is a highly metapsychological and abstract account, and is not at all useful in understanding repetitive behavior at the clinical empirical level. I do not know of any analysts, including Freudian analysts, who would invoke the death instinct in providing an explanatory account for any specific pathological behavior.

Freud (1939) provided examples of the compulsion to repeat that appear to have little to do with the death instinct. In one example, he described a hypothetical "man who has spent his whole childhood in an excessive and today forgotten attachment to his mother, may spend his whole life looking for a wife on whom he can make himself dependent and

by whom he can arrange to be nourished and supported" (p. 75). In another example, he refers to "a girl who was made the object of sexual seduction in her early childhood may direct her later sexual life so as constantly to provoke similar attacks" (pp. 75–76). Note that in both of these examples, Freud refers to repetition of *relationship* patterns. As we shall see, the repetition of relationship patterns is also the focus of post-Freudian attempts to understand the unchanging nature of pathological behavior. Before turning to these developments, I will briefly discuss two other interrelated concepts that Freud invoked in order to account for people's failure to change: the negative therapeutic reaction and masochism.

Negative Therapeutic Reaction and Masochism

Freud (1923) attributed the "negative therapeutic reaction"—that is, resistance to change and continued suffering, in treatment, as well as a general reluctance to give up one's illness—to an unconscious sense of guilt and a consequent masochistic need to suffer and to receive punishment (pp. 49–50). Just as positing a compulsion to repeat hardly represents an adequate explanation of repetitive behavior, so the positing of a need for punishment as an explanation of a negative therapeutic reaction or of self-destructive behavior or of persistent suffering also hardly constitutes adequate explanation unless one can independently assess, for a given individual, his or her need for punishment—an assessment that Freud does not generally provide. Without such an assessment, Freud's explanation would appear to be circular. That is, self-destructive behavior is accounted for by guilt and the need for punishment, and the evidence for the guilt and need for punishment is largely the intensity and pervasiveness of self-destructive behavior.

Mastery

Finally we come to the factor of mastery in Freud's attempts to account for repetitive behavior. In one of his works, Freud (1920) describes the play of a 1-year-old child who over and over again repeats the pattern of dropping an object (that was attached to a string) out of sight, accompanied by a fragmentary form of the German word "fort" (which means "gone"), and then pulling it into sight and uttering "da" (which means "there"). One interpretation of this play behavior that Freud offers is that the child—who endured his mother's absences of a few hours without ever crying—was attempting to master a situation in which he had been *passive* by repeating

it, but this time taking an active part. That is, he is now actively controlling the disappearance and reappearance of the object. According to Freud (1920) such an "instinct for mastery" can act "independently of whether the memory was in itself pleasurable or not" (p. 16). What Freud is suggesting here is that one can repeat in an *unpleasurable* experience or memory—a fact that on the face of it seems to contradict the pleasure principle—for the purpose of mastery.

Although the compulsion to repeat, the negative therapeutic reaction, moral masochism, and attempts at mastery are all characterized by repetition, one must distinguish the kind of repetition involved in mastery from these other more pathological forms of repetition. Central to the concept of mastery is the idea that one repeats an experience or behavior *in order to change it*. While the repetition compulsion, the negative therapeutic reaction, and moral masochism all involve, so to speak, endless repetition, implicit in the idea of mastery is a limited repetition.

Loewald's (1980) idea of "re-creative repetition"⁵ has implications for one's concept of transference and for the role of analysis of the transference in therapeutic change. According to traditional Freudian theory, since the patient's transference reactions largely involve the attempt to gratify infantile wishes and the repetition of characteristic conflicts, anxieties and defenses, transference reactions are a primary expression of the patient's *resistance to change*. According to more contemporary views, however, transference repetition can be in the service of mastery rather than gratification. This increased emphasis on mastery is seen in Loewald's (1980) concept of "re-creative repetition" (p. 68) and, as we shall see, is especially evident in Weiss and Sampson's (1986) "control-mastery theory." In this latter theory, the explicit claim is made that, at least in part, underlying the repetition of transference reactions are motives for mastery.

Implicit in the concepts of mastery and "re-creative repetition" and in Weiss and Sampson's (1986) "control-mastery" theory is the idea that under certain conditions and seemingly paradoxically, repetition can be in the service of change rather than resistance to change. Before turning to Weiss and Sampson's work, however, I want to note briefly that there are some varieties of resistance that I have not dealt with in this chapter, but should be at least noted. One important source of resistance can be rooted in the *secondary gain* that one derives from one's symptoms and one's maladaptive patterns. Very often, unless one deals with the issue of second-

⁵This issue also arises in the context so-called "object choice," that is, the choice of one's partner in an intimate relationship. As Blum and Shadduck (1991) point out, although one is repeating when one chooses a spouse that is like one's parent, the question is "to what degree is this choice an endlessly tormenting repetition versus a challenge that leads to reworking and growth of the self" (p. 63).

ary gain, behavior will not change. The concept of secondary gain implies that factors that *maintain* maladaptive behavior may be relatively independent of the original etiological factors.

Another important source of resistance that has been noted is the conscious or unconscious fear that change will threaten an important relationship. In such cases, preserving the status quo is tantamount to preserving the relationship. Haffner (1984) has reported that following symptomatic improvement in a group of agoraphobic women, their husbands showed increased symptomatology. When these women “gave up” their improvement, their husband’s symptomatology abated. In such cases, it is likely that the symptom helps preserve a degree of equilibrium in the family and that resistance is motivated by a fear of threatening that equilibrium.

New Psychoanalytic Perspectives on Repetition

There are a number of post-Freudian attempts to deal with the question of why people don’t change that are characterized by a rejection and/or reconceptualization of Freudian accounts. In this section, I will discuss a number of formulations that are linked to the “control-mastery” theory of Weiss, Sampson, and their colleagues (1986), attachment theory, object relations theory, and self psychology. Implicit in control-mastery theory is the basic idea that underlying repetitive pathological behavior are “unconscious pathogenic beliefs” that, so long as they remain unexamined and unmodified, will tend to keep behavior stereotypically unchanged. Also implied in the theory is the expectation that people’s behavior will tend to change when pathogenic beliefs are disconfirmed or markedly modified.

The Control-Mastery Theory of Weiss and Sampson

Control-mastery places a primary emphasis on the patient’s attempts at mastery of “unconscious pathogenic beliefs” that have been acquired in one’s early interactions with parental figures and that represent the primary source of neurotic distress and symptomatic behavior.

There are a number of factors that tend to keep pathogenic beliefs unexamined and unmodified. One, they are most often acquired early in life when self-reflective capacity is minimal. Two, the early parental messages that form the basis for pathogenic beliefs are often communicated indirectly and are never made explicit. Three, once acquired, pathogenic beliefs (as well as internal working models) influence subsequent interac-

tions and perceptions of interactions so as to confirm these beliefs (see Eagle, 1995, for a further discussion of these issues).

Let me provide a specific example of an unconscious pathogenic belief. Modell (1983) refers to "separation guilt" or "survivor guilt" as the guilt that some people suffer in connection with their normal strivings toward separation and autonomy. Such guilt can be understood as being linked to the unconscious pathogenic belief, based on early and repeated implicit messages, that separating from one's parents and leading an independent life is tantamount to seriously harming or destroying them. In my clinical experience, separation guilt and survivor guilt are often centrally implicated in agoraphobia. The fantasy that "if I leave home I will not survive" is often close to the surface and, indeed, is, in some ways a phenomenological description of the experience of the agoraphobic symptom. The unconscious fantasy or pathogenic belief, however, that "if I leave home mother (or father) will not survive" or, as a variant of it, "if I leave home and lead an independent life, *I deserve* not to survive," tend to emerge only later in treatment, and illustrates the "separation guilt" and "survivor guilt" discussed by Modell.

According to control-mastery theory, patients come to treatment not, as Freud maintained, driven by peremptory attempts to gratify infantile wishes, but trying to find a way to *disconfirm* their distress-causing pathogenic beliefs. They attempt to disconfirm pathogenic beliefs by unconsciously presenting *tests* to their therapists that can be either *passed* or *failed*. Passing of a test essentially consists in therapist responses that tend to disconfirm the patient's unconscious pathogenic beliefs and failing a test consists in the therapist responses that tend to confirm the patient's pathogenic beliefs. These failures by the therapist may be a central reason why such repetitions do *not* lead to change. Let me provide an illustrative example.

A young man, after being in analysis for a period of time, brings a gift to his male analyst. The analyst tactfully refuses the gift, in part because it violates the analytic contract and is equally tactful in not offering interpretations of the patient's motives for the presentation of the gift. During the next session, for the first time in the treatment, the patient begins talking about his homosexual fears and fantasies. I am not suggesting that there is only one way to interpret this sequence of events. One plausible interpretation, however, that would be generated by control-mastery theory, is that the patient's presentation of the gift unconsciously represented a test to determine whether or not the analyst was easily seducible. The analyst's tactful refusal of the gift constituted test passing, which then made it safe to bring into awareness and into the therapeutic session hitherto warded off material.

It will be noted that control-mastery theory's conceptions of transference and resistance are strikingly different from the traditional Freudian view. Transference repetition is now understood primarily as an attempt at mastery rather than as an expression of the instinctually determined compulsion to repeat. The prototypic patient of control-mastery is, in certain respects, like the child described by Freud playing the "fort-da" game. That is, he or she reenacts an experience or pattern that is fraught with difficulty and anxiety in order to achieve active mastery.

According to control-mastery theory, maladaptive behaviors persist and are resistant to change primarily because they are based on pathogenic beliefs that have been acquired early in life and, given their unconscious status, have remained unexamined and unmodified and possibly because of one's fear that if one's pathogenic beliefs are put to the test, they will once again be confirmed: an experience that would constitute *retraumatization*. Control-mastery theory does not assume that maladaptive symptomatic behaviors are gratifying in themselves. Implicit in control-mastery theory is the idea that at least some symptomatic behaviors are maintained (i.e., are resistant to change) because they serve *anxiety and guilt avoiding functions*. Thus, if, for example, one harbors the pathogenic belief that becoming an autonomous person and separating from one's parents will destroy them, one can avoid the anxiety and guilt associated with such fantasized destruction by *not* separating and *not* becoming a full autonomous person. The behavior that remains unchanged is not necessarily due to resistance to getting better or to some ultimate organically based repetition compulsion, but to the persistence of unconscious fantasies and beliefs. If these fantasies and beliefs are disconfirmed and relinquished in treatment, behavior will change.

Attachment and Object Relations Theories

A basic observation that engendered concepts such as transference, resistance, and repetition compulsion is that, particularly in emotionally important and intimate relationships, people tend to repeat their typical relationship patterns—even when this pattern is associated with distress and suffering. A frequent reason that people seek psychotherapy is that they are enmeshed in an unsatisfying relationship (or have been enmeshed in a series of them) or are suffering from symptoms and dysphoric feelings that appear to be linked to troubled relationships (Strupp and Binder, 1984).

A core assumption in both Freudian and post-Freudian psychoanalytic theories is that one's typical adult relationship pattern is similar, in important ways, to the relationship one established early in life with one's parents.

Another core assumption cutting across both Freudian and post-Freudian theories is that the basic relationship pattern established early in life is repeated in the interaction with the therapist. The assumption is, of course, the essence of the concept of transference. A core question addressed by any psychoanalytic or psychodynamic theory is why people repeat a particular relationship pattern even when it brings them disappointment and suffering, and even when their conscious goal is to change that pattern. A distinctive characteristic of post-Freudian formulations particularly of attachment and object relations theories is that the general question of why people don't change becomes, in large part, transformed and distilled into why people don't change the *relationship patterns* that bring them disappointment, distress, and suffering. Some light has been shed on this issue by attachment research during the last number of years.

There is a good deal of evidence that infants develop characteristic patterns of attachment (e.g., Ainsworth, Blehar, Waters, and Wall, 1978) and that these attachment patterns remain fairly stable over long periods of time (e.g., Sroufe, 1990). A number of attempts have been made to describe possible processes that would account for such stability. These attempts have in common the basic idea that in the course of interacting with their caregivers, infants and children develop *internal mental representations* of the caregiver (as in Bowlby's [1973] "internal working model") and/or of repeated typical interactions with the caregiver.

What is suggested by the above concepts is that we have come to represent specific episodes and events, including repeated early interactional experiences, in terms of generalized and invariant features that appear to best represent and cut across the specific episodes and interactions. Nelson and Gruendel (1981) refer to these representations as "General Event Representations." Stern's (1985) "Representations of Interactions Generalized" or "RIGs," and Beebe and Lachmann's (1988) "interactional structures," refer to similar generalizing processes that represent the invariant or prototypic features of repeated interactions.

The assumption is often made that, once formed, these internal mental representations of the self, the caregiver, and of typical and generalized interactions with the caregiver (1) are relatively stable and resistant to change, (2) strongly influence the perceptions and expectations that we bring to new relationships, and (3) that because of this influence, we tend to *form and transform* relationships so that they conform to our early acquired expectations and schemas. One of the primary ways that we do this is to *behave* in particular ways that will elicit just those responses from the other that will tend to perpetuate early relationship patterns.

This account is essentially a learning theory in which what is learned are mental representations that are held to be highly resistant to change

and to have a strong determinative effect on later relationship patterns. It states, for example, that self, object, and interactional representations or “internal working models” that are acquired early in life and that are based on early interactions with parental figures become the implicit prototype for one’s conception of the other, particularly in intimate relationships (which share some of the same emotional features as one’s early relationship with parental figures). These “interactional structures” include implicit ‘rules’ regarding one’s own behavior and feelings and implicit expectations regarding how the other will react in important relationships. Hence, once acquired, interactional structures may serve to guide and determine subsequent relationships.

A major question here is just how important early “internal working models” and interactional structures are in influencing subsequent relationships later in life. A basic assumption that has always characterized psychoanalytic theories is that certain early events in infancy and childhood play a determinative role in shaping personality structure. The current emphasis on the role of early models and interactional structures is simply one contemporary version of this basic assumption. If early interactional structures do, indeed, shape the nature of future relationship patterns, this would be a very powerful force in maintaining the sameness of behavior and in accounting for why people don’t change.

In the above, little has been said regarding the *motives* for the repetition of interactional patterns. The emphasis has been on learning and on the *automatic* tendency to assimilate new experiences to preexisting cognitive structures. Or, to put it in a somewhat different way, one’s *expectations* regarding the behavior of others will be based on one’s experiences with one’s early attachment figures. So, for example, if one has an internal working model of an attachment figure as unavailable, then one may be likely to expect new attachment figures to be unavailable. This account does not have a prominent motivational component. One repeats interactional patterns because of what one has come to expect of others and because of what one has learned. Attachment theory does introduce a general motivational factor in describing the basic function of internal working models as a way of rendering the world predictable and manageable. As Bretherton (1987) notes, “with the aid of working models, the individual perceives and interprets events, forecasts the future, and constructs plans” (p. 1066).

Another motivational factor that may be involved in the maintenance of sameness is the idea that established attachment patterns tend to be maintained and are difficult to relinquish because, however unsatisfactory they may be, they provide some degree of security and meet, at least to some degree, one’s attachment needs.

There is evidence among infrahuman species that even abusive behavior from the attachment figure does not necessarily serve to weaken the intensity of the infant's attachment, but in many cases serves to *strengthen* it (Rajecki, Lamb, & Obmascher, 1978). One often finds a similar pattern with abused children who continue to cling and remain loyal to abusing parents and also with abused women who often give as their reason for returning to the abusing man, "I love him." Attachment theory helps one understand these disturbing and puzzling phenomena. For one thing, the only security available for the infant is the abusing attachment figure. Further, as Bowlby (1969) has observed, when one is afraid or in pain, attachment needs and responses are intensified, and the infant has little choice but to turn to the attachment figure, even when that figure is the source of the fear or pain. The degree to which more subtle versions of this pattern occur in adulthood needs to be investigated.

Mitchell (1988) suggests that people often seek out what can clearly be defined as unsatisfactory relationships, because such relationships have come to represent the prototype of some degree of security. He presents a clinical example of a man whose mother was available to him when he was a child mainly when she was depressed. As an adult, this man not only selected depressed women, but sought to recreate a relationship pattern in which the woman would become depressed. For this man, relating to a depressed woman was associated with security, and was therefore actively sought and repeated. Hence, while this man might, on a conscious level, complain that his wife is depressed and that he has had the bad luck of frequently getting involved with depressed women, at an unconscious level he seeks to repeat the relationship pattern in which he is relating to a depressed woman. This can come about in at least two ways: One, through what is referred to in the psychoanalytic literature as "object choice." That is, he may unconsciously seek out women who emit cues that suggest a strong tendency to depression; and two, by *transforming* new relationships so that they become new versions of old repetitive patterns—that is by inducing depressions in the woman with whom he is involved. These two processes are interrelated insofar as it is easier to induce depression in a woman who already has strong tendencies in that direction. Both processes operating together represent a very potent force in maintaining interactional patterns and cognitive-affective reactions with which they are associated (see Wachtel, 1982).

Fairbairn (1952) has commented that becoming aware of one's repressed internalized objects in treatment is not nearly as difficult as giving up one's "devotion" to these objects. He also refers to an "obstinate attachment" that one maintains to one's early objects. As Greenberg and Mitchell (1983) put it in their discussion of Fairbairn, "the re-creation of the sorrow,

suffering, and defeat are forms of renewal and devotion to these [internal] ties" (p. 174). What Fairbairn is referring to is the strange kind of unconscious loyalty that people often show to early figures and to early interactional patterns. Even if it repeatedly brings misery and suffering, a particular way of relating and of living often is clung to with a seeming fierce loyalty—as if to relate and live differently were equivalent to snuffing out one's past and the important figures in the past. To relate and live differently not only involves betrayal of one's early figures and its attendant guilt (recall Modell's [1983] concept of "survival guilt"), but is experienced as equivalent to living in a psychological world that has been emptied of those self, object, and interactional representations that normally make up one's inner world and that define oneself. Such a world indeed approximates the "objectless world" (that is, a world without a defined identity and without "objects" to whom one is deeply attached) that, according to Fairbairn, represents the ultimate psychological danger and terror that one can confront.

Some years ago I treated a Canadian Indian man whose pattern of behavior seemed to illustrate the kind of "devotion" to early objects described by Fairbairn. This young man had a history of self-destructive behavior, including drinking sprees accompanied by quasi-suicidal actions such as speeding and, one occasion, falling into a drunken sleep outdoors throughout a cold and wintry night in Toronto. This young man had earned a master's degree in English and was a talented poet, as attested to by a number of published poems that had been quite well received. His history revealed a rigid, repetitive pattern in which his experience of any success and good fortune (e.g., some feeling of relative well-being, a decent job, a poem accepted for publication) was invariably followed by self-destructive behavior and an exacerbation of depression and/or rage.

What was most striking about this patient was the degree to which his success in the white man's world was experienced, in a very profound way, as a betrayal of his own background and his own people. Or, put another way, the patient's life style, including his self-destructive behavior, was experienced, at some deep level, as an expression of loyalty, and as a way of maintaining ties to his own background and the early world of his origins.

For this young man, to live differently was to abandon his past. If the re-creation of suffering and defeat are forms of *devotion* to one's early internal ties, then to live differently and reduce suffering is to *betray or destroy* these ties. Furthermore, as I have described above, not only does such betrayal evoke guilt (the aspect of pathology emphasized by Weiss and Sampson [1986]), but more fundamentally, to destroy one's early ties, for some people, is equivalent to living in a terrifyingly empty inner world that is devoid of objects and internal ties.

It will be noted that in the above we are once again dealing with a variant of individuals' basic fear that changing their behavior will expose them to *greater danger* than they are now facing and greater distress than they are now suffering. According to object relations theory (and, to a certain extent, attachment theory), this greater danger—indeed, the ultimate danger—consists not in the excessive excitation emphasized by Freud, but in the prospect of experiencing an inner world that is *empty and devoid of familiar affective ties*.

Let me pause for a moment and summarize some of the main features of what has been discussed thus far. In post-Freudian psychoanalytic formulations, the following interrelated factors have been highlighted in accounting for the sameness of behavior: (1) unconscious pathogenic beliefs based on early interactions with parental figures and often characterized by maladaptive links between normal developmental strivings and guilt toward parental figures; (2) the establishment of early self, object, and interaction representations that serve as prototypes for later relationships and that appear to be highly resistant to change; (3) meeting one's security and attachment needs in a way that reflects early learning and early prototypes; and (4) the basic and unconscious fear that loosening or relinquishing one's early internal ties will result in the loss of identity and the terrifying experience of living in an objectless inner world.

In a certain sense, all the above factors are consistent with a broad version of the pleasure principle. That is, people pursue and repeat maladaptive behavior patterns because they fear that to do otherwise would result in greater dangers and greater distress than they are now facing and enduring. At least as far as post-Freudian psychoanalytic formulations are concerned, there appears to be no need to go "beyond the pleasure principle" and to invoke new and mysterious organically grounded imperatives and compulsions in order to account for the repetition of maladaptive behavior.

The central Freudian idea that pathological repetition is partly accounted for by the continued pursuit of infantile aims is also retained in some form in post-Freudian psychoanalytic formulations, but is markedly modified, perhaps to the point of unrecognizability. Thus, the repetition of early relationship patterns as a means of meeting one's security and attachment needs is, in a sense, the continued pursuit of infantile aims. However, in contrast to Freud, the contemporary object relations and attachment theorists would maintain that security and attachment needs are *lifelong* ones and not simply to be characterized as infantile aims that need to be relinquished in adulthood. At most, what needs to be relinquished, or at least modified, is *the maladaptive way in which one goes about meeting these lifelong needs*. A similar point can be made regarding Fairbairn's (1952) earlier noted comment on the pathological "devotion"

to internalized objects. The need for internal ties and the terror of an objectless inner world are lifelong issues. The therapeutic change to be aimed for is not relinquishment of the need for internal ties or of the terror of living in an objectless world, but alterations in the *kind* of internal ties one develops. That is clearly what Fairbairn (1952) had in mind when he described the goal of treatment as the replacement of a "bad object situation" with a "good object situation." It is also what Kohut (1984) has in mind when he discusses the importance of altering the kinds of selfobject ties one experiences rather than eliminating the need for selfobjects themselves. Thus according to Kohut (1984), the need for self-sustenance from what he calls selfobjects is a lifelong one and is not replaced, in the course of development, by independence and autonomy. What needs to occur in normal and healthy development is to alter *the ways in which* one attempts to get sustenance from selfobjects. In the course of healthy development or successful psychotherapy, one will move from archaic selfobject ties, which are characterized by demands for perfect empathic understanding or fantasies of merging with a powerful idealized figure, to increasingly mature selfobject ties in which one can benefit from imperfect and good enough empathic understanding and good enough qualities in another that one can admire.

Similarly, in the course of healthy change, one continues to attempt to meet one's needs for security, but not through repeating a familiar abusive relationship. Or, as a final example, one continues to need affective ties, but rather than attempting to meet these needs through "devotion" to early objects, one becomes affectively involved with contemporary figures.

PSYCHODYNAMIC RESEARCH ON THERAPEUTIC CHANGE

Freudian Hypotheses: Repression and Resistance

As we have seen, according to Freudian theory, repression of infantile wishes and resistance to relinquishing them play a central role in the maintenance as well as the origin of neurotic symptoms and behavior. How would one go about testing these hypotheses in a relatively rigorous and systematic way? Breuer and Freud (1893–1895) thought they had demonstrated that the lifting of repression of a specific memory (or wish) was followed by amelioration of the particular symptom with which the memory was linked. However, there are serious questions as to whether they successfully demonstrated that link (e.g., see Grunbaum, 1984). Trying to study the nature of the relationship between repression and change in behavior is fraught

with difficulties, among them determining the causal direction of the relationship and reliably measuring repression.

Although attempts to demonstrate experimentally the existence of repression (as defined by Freud) have not been successful, there is a recent fascinating research literature suggesting that "repressive style" as a personality trait is associated with a variety of maladaptive factors, including susceptibility to specific illnesses (e.g., hypertension), increased physiological arousal, and greater release of stress-related hormones (Weinberger, 1990). In these studies, repressive style is generally operationally defined as the combination of a self-report of low anxiety and high defensiveness (e.g., measured by the Marlowe-Crowne Scale; Weinberger, 1990). Thus, although repressive style is certainly not identical to the Freudian concept of repression, it bears a "family resemblance" to it insofar as both are based on "the fundamental proposition that repression serves to keep painful, unpleasant experiences out of consciousness or awareness" (Davis, 1990, p. 388).

As for the relationship between undoing repression and change, there is suggestive evidence that confronting and disclosing traumas (e.g., by writing about them for four consecutive days) is associated, on follow-up, with a better immune response, fewer health center visits, a decline in systolic blood pressure, and self-reports of feeling happier (e.g., Pennebaker, Kiecolt-Glaser, & Glaser, 1988). Although this research does not specifically deal with repression—there is no evidence that the memories for the traumas were repressed—the findings, suggesting that confronting (and disclosing) material that one may have defensively avoided may lead to positive change, are congruent with the psychoanalytic proposition linking lifting of repression to positive change.

As for the relationship between resistance and change, as Schuller, Crits-Christoph, and Connolly (1991) have recently pointed out, although resistance is a central concept in the psychoanalytic understanding of treatment, there has been remarkably little systematic research on the topic (e.g., Garduck & Haggard, 1972; Graff & Luborsky, 1977; Luborsky, Sackheim, & Christoph, 1979; Morgan, Luborsky, Crits-Christoph, *et al.*, 1982; Speisman, 1957). The studies that have been done have primarily been concerned with measuring resistance and linking measures of resistance to intervention (mainly, interpretation) vs. nonintervention in treatment. There have been attempts to develop a multidimensional scale of resistance based on therapeutic session segments and compare resistance measures immediately following an interpretive intervention to those taken after a control nonintervention segment (Schuller *et al.*, 1991).

There are a limited number of studies on the relationship between resistance and therapeutic outcome or likelihood of change. Using the analyst's postsession ratings in four psychoanalyses, Graff and Luborsky

(1977) found a decrease in resistance in two cases judged to be relatively successful, and did not find this in the two less successful cases. Luborsky *et al.* (1979) judged three patients' speech segments before and after transference interpretations on a number of dimensions, including resistance, and found that there was an increase in resistance in reaction to resistance interpretations for the patient whose therapeutic outcome was considered unsuccessful and a tendency for a gradual decrease in resistance for the moderately and highly improved patients. While these studies are provocative in suggesting future research, given obvious weaknesses in design (e.g., use of analyst's ratings of resistance, possible confounding between resistance and outcome judgments, no clear resistance criteria, small *Ns*), there is little one can securely conclude regarding the relation between resistance and outcome.

Recent Psychodynamic Research on Therapeutic Change

During the last 20 or 30 years, a number of psychoanalytically and psychodynamically oriented investigators have carried out research relevant to the question of the conditions under which people do and do not change in psychoanalytically oriented treatment (e.g., Dahl, [1972]; Luborsky and his colleagues [e.g., 1988], Weiss, Sampson, and their colleagues [1986], Silberschatz and his colleagues [e.g., 1986, 1989], Strupp [e.g., 1973], and Malan [1963]). In the following sections, I will describe the work of Weiss and Sampson and their colleagues, Luborsky and his colleagues, and research on repetition of attachment and early relationship patterns. This work is selected because it is relevant to the issue of resistance to change.

The Research Program of Weiss and Sampson

I begin with a brief summary of the research program of Weiss and Sampson (1986) and their colleagues. Weiss and Sampson have attempted to subject their ideas about control-mastery theory to empirical test. They have shown, using detailed process notes and transcripts of psychoanalytic sessions, that independent judges can reliably agree regarding the nature of the patient's unconscious plan; which contents have been warded off; when the patient has presented a test to the analyst; and whether the analyst has passed or failed the test. They have also shown that test passing is reliably followed by the patient becoming less anxious, more relaxed, more flexible and spontaneous, bolder in tackling issues in treatment, and friendlier toward others.

It is clear that Weiss and Sampson are proposing a theory of therapeutic change as well as a theory of why people persist in their maladaptive and distressing behaviors—that is, a theory of why people don't change. One of the basic reasons that people don't change easily is that in important areas of life (e.g., separating from one's family, being successful, being assertive, pursuing one's needs) their behavior is governed by unconscious pathogenic beliefs that were acquired in relation to early paternal figures, but that continue to operate in relation to current significant figures in one's life (see earlier summary of control-mastery theory). According to control-mastery theory, people *do* change in therapy, or at least are more likely to change, when, after presenting tests to the therapist, the therapist responds in such a way as to disconfirm their pathogenic beliefs.

Weiss and Sampson's research findings deal almost exclusively with changes that occur within the therapy sessions. No systematic data on outcome are reported. Thus, we do not know from these findings whether therapeutic processes such as test-passing are lawfully linked to long-term behavioral changes outside treatment.

Silberschatz and his colleagues have begun to address this issue by presenting outcome data in the context of control-mastery theory. According to control-mastery theory, the patient comes to treatment with an *unconscious plan* regarding what is necessary to disconfirm his or her unconscious pathogenic belief—that is, what is necessary for positive change to occur. Silberschatz and his colleagues attempted to relate the therapists' "proplan" and "antiplan" interventions to therapeutic outcome. The basic hypothesis was that "proplan" interventions would be associated with positive therapeutic outcome and "antiplan" interventions with negative therapeutic outcome. Silberschatz *et al.* (1986) reported that for two cases showing very good and moderately good outcome, respectively 89% and 80% of the therapists' interventions were independently rated as "proplan" (that is, furthering the patient's unconscious plan), while 2% and 0%, respectively of the interventions were "antiplan." By contrast, in a case showing poor outcome, 50% of the therapists' interventions were rated as "proplan," 6% as "antiplan," and 44% as "ambiguous." Silberschatz *et al.* (1989) found that when the therapist was rated low on test passing, the result was poor outcome "as defined by conventional therapeutic outcome measures" (p. 44); and conversely, when the therapist was rated high on test passing, the result was good outcome.

Research Program of Luborsky and Colleagues

Let us turn now to the work of Luborsky and his colleagues. A book by Luborsky and his colleagues (1988) presents many findings from their

research program on psychoanalytic therapy. It should be noted that Luborsky's work deals primarily with how and why people change when they do change rather than with the questions of why it is difficult for them to change and the factors responsible for such difficulty. However, some of the findings have implications for the issue of resistance to change in the context of psychotherapy. Luborsky has developed a scoring scheme in which the patient's relationship episodes narrated in treatment can be reliably broken down into the wish or need the patient expresses (W), the response from the other (RO), and the subsequent reaction of the self (RS). Further, one can reliably find for each patient predominant or core conflictual relationship themes (CCRT). According to Luborsky *et al.* (1988), one finds the following pattern in successful treatment from early to late treatment sessions:

1. Relative stability in the main wish or need expressed.
2. A decrease in the percentage of negative responses from the other.
3. A decrease in the percentage of negative responses from the self.
4. An increase in the percentage of positive responses from the other.
5. An increase in the percentage of positive response from the self.

As one can see from the above, it appears that even in successful treatment, the main wish or need expressed by the patient tends not to change. What does change is the experienced reaction of the other to one's expressed need or wish and one's own subsequent reaction to the response of the other. According to Luborsky, the most important therapeutic element in effecting change is the patient's experience of a helping alliance or relationship. This general factor includes a "Type 1" helping alliance, which refers to the patient's experience of the therapist as helpful and supportive, and a "Type 2" helping alliance, the predominant characteristic of which is the patient's experience of working together with the therapist in a joint effort and struggle.

One can link the importance of the helping alliance to the CCRT changes in experienced responses from others and from the self. According to traditional psychoanalytic theory, the neurotic individual's wishes are linked to conflict and anxiety and set off "expected or remembered helplessness" (Freud, 1926). If the patient has been able to express these wishes in the therapy situation, and has experienced the therapist's responses as helpful and supportive, then the patient will come to modify his or her experience and expectation of a negative response from the other and from the self. According to Luborsky *et al.*, these changes indicate that the patient has developed an increased sense of mastery and a decreased sense of helplessness in dealing with his or her core relationship problems.

Implied in the findings reported by Luborsky and his colleagues, even

if not explicitly stated, is the idea that the less the patient experiences the therapist as helpful and supportive and the less the patient experiences the therapy as a joint effort—that is, the weaker the therapeutic alliance—the more one might expect to see resistance and/or lack of change. (Note that this conclusion is also entirely in accord with the control-mastery theory of Weiss and Sampson.)

Research on Repetition of Relationship Patterns

There is a good deal of research in the attachment literature suggesting that attachment patterns established in infancy and early childhood are stable over time and may even be carried over into adult relationship patterns (e.g., Cicchetti, 1989; Main & Goldwyn, 1984; Main, Kaplan, & Cassidy, 1985). Following Bowlby (1973), many attachment theorists have hypothesized that mediating the temporal stability of attachment patterns is the construction of “internal working models.” As noted earlier, according to Bowlby and other attachment theorists, based on early experiences, infants and children construct internal working models of the caregiver, of the self, and of prototypical self–caregiver interactions. The basic function of these internal working models is to render the world predictable and manageable, and to permit the development of strategies to deal with the world (Bretherton, 1987). What makes this area of research and theory relevant in the present context is the claim that once established, internal working models are relatively resistant to change. The general idea seems to be that once one has developed a serviceable working model that enables one to experience the world as relatively predictable, one is reluctant to give it up, with the result that there is a tendency for information and experiences that are incompatible with the existing working model to be assimilated to that model.

Implicit in attachment theory is another source of stability of attachment pattern that has little directly to do with resistance to change. Nevertheless, it contributes to the prevention of change. I am referring to evidence related to behaviors that tend to confirm and perpetuate one's working model—thus creating the familiar vicious cycle that seems to repeatedly emerge as a significant factor in maladaptive relationship patterns (see Strupp & Binder, 1984; Wachtel, 1982).

As examples of this research, Jacobson and Willie (1986) report that, although they make as many social overtures as securely attached children, insecurely attached 3-year olds elicit fewer positive responses from an unfamiliar playmate. Thus, in an initial encounter with an unfamiliar peer, security of attachment appears related to social attractiveness as an inter-

active partner. The insecurely attached child seems to emit cues that elicit rejecting behavior in the unfamiliar playmate.

Sroufe (1990) reported that teachers of preschool children, blind to the attachment history of the children, judged children with a history of secure attachment to be more independent and resourceful than children with a history of an avoidant attachment pattern. Six years later camp counselors provided congruent data. Furthermore, critically important in understanding the later reinforcement of early attachment patterns, the teachers behaved differently toward securely and insecurely attached children. They tended to be warm, uncontrolling, positive, and age appropriate toward securely attached children, and scored significantly higher on control/negative expectations for compliance and anger in their behavior toward avoidant children. Sroufe remarks that this behavior is "quite reminiscent of what these children had experienced with their caregivers" (p. 299). For anxious/resistant children, teachers "were unduly nurturant and tolerant of rule violations, but again controlling and with low expectations" (p. 299), behaviors that Sroufe notes, "are in remarkable accord with patterns of adaptation shown by the children and therefore confirmed the children's working models of self" (p. 299). The above evidence suggests that children behave in a way that tends to call forth behaviors in others, both children and adults, that serve to confirm and perpetuate early attachment patterns and the internal working models generated by early attachment experiences. (See Eagle [1996] for a further discussion of this issue.)

There is evidence that resistance to change in one's inaccurate internal working model is associated with perpetuation of maladaptive relationship patterns. Thus, Main and Goldwyn (1984) reported that idealization of the mother and failure to recall concrete early attachment experiences on the Berkeley Adult Attachment Interview were associated with a subject's rejection of her own child. Contrastingly, evidence that the interviewed mothers had remembered, confronted, and attempted to work through their early attachment experiences—that is, evidence that the mothers had attempted to revise their internal working models—was inversely related to rejection of their own infants.

Main and Goldwyn (1984) conclude that "a cognitive-affective reworking of the "internal working model" of the self in relation to early parent-child relationships" (p. 215) is crucial in preventing the repetition of abused-abusing or rejected-rejecting relationship patterns. Their conclusion is virtually identical to the one reached by Cicchetti (1989), who suggests that "the reworking of existing poor quality internal representational models of attachment relationships, alone and/or in therapy . . . seems like an effective prescription for preventing the occurrence, recurrence

(within a family), and intergenerational transmission of child abuse and neglect" (p. 389).

The above formulations should be viewed, not as firm conclusions, but as plausible hypotheses that require further empirical investigation. As Main and Goldwyn (1984) state, "We need to know what leads some individuals to 'repetition' of malignant experience, whilst others are led from 'remembering' earlier experience to its 'working through' (p. 215).

IMPLICATIONS FOR CLINICAL APPLICATIONS

The Role of Resistance and Transference

Different psychoanalytic theories are characterized by different accounts and conceptualizations of resistance, as well as of transference. Thus, for Freud, resistance is understood as a reluctance to become aware of and relinquish infantile wishes. For both Weiss and Sampson's control-mastery theory and Kohut's self-psychology, resistance is conceptualized as a fear of retraumatization at the hands of the therapist. However, common to both Freudian and contemporary psychoanalytic theories is the assumption that a good part of psychoanalytic work consists in analysis of the patient's defenses. Since resistance can be understood as the operation of defense in the treatment, the prescription that a major part of analytic work should consist in the analysis of defense is tantamount to suggesting that the major task in psychoanalytic treatment consists in dealing with the patient's resistances. Insofar as a major expression of resistance in psychoanalytic treatment is the patient's development of transference reactions, the emphasis on analysis of the transference is also tantamount to giving primacy to dealing with the patient's resistances.

Although perhaps not always made fully explicit, it seems to me that an assumption common to different psychoanalytic theories is that an important source of resistance to change is the individual's fear that change will entail danger, pain, and anxiety. (This is also a central idea in Sullivan's [e.g., 1953] interpersonal theory as well as in nonpsychoanalytic research and theory on the stability and resistance to change of self-conception and cognitive belief structures [e.g., Greenwald, 1980].)

However, the nature and the source of the danger and anxiety facing the change-resistant individual is conceptualized very differently in contemporary psychoanalytic theory than it is in Freudian theory. From the Freudian perspective, the major source of anxiety against which the individual defends is the conscious awareness of forbidden wishes. In more contempo-

rary formulations, the major source of danger and anxiety can broadly be referred to as *fear of retraumatization* at the hands of the therapist.

One important implication of the above reconceptualization of resistance (as well as transference) is that the patient's increased resistances may serve as a sign that the patient feels *unsafe*, and further, that such feelings of danger may be related to messages and cues communicated by the therapist, most often unwittingly communicated. What this means on a very practical level is that when increased resistances occur, the therapist needs to try to identify the nature of the cues communicated, including how he or she has "failed" the patient. This means greater sensitivity, on the part of the therapist, to how he or she interacts with the patient. In the psychoanalytic literature, much of this material is discussed under the rubric of *countertransference*. The "classical" notion of the analyst as a "blank screen" has been abandoned and has been replaced in contemporary psychoanalytic theories with the assumption that the patient's feelings and behavior, including manifestations of resistance, will be strongly influenced by the cues communicated by the therapist (e.g., subtle, nonverbal expressions of boredom, annoyance, competitiveness, or anxiety). This means that the therapist must always be sensitive to the impact he or she is having on the patient.

The Role of Awareness and Insight

It will be recalled that in the research on intergenerational transmission of abuse and neglect, mothers who do not have access to and have not been able to integrate their experiences of rejection are more likely to repeat the pattern of rejection with their infants, while those who can remember and integrate are less likely to repeat. This finding provides support for Freud's (1914, 1920) claim that one is more likely to repeat when one does not remember and suggests that the marked deemphasis on the therapeutic role of awareness and insight characteristic of the recent psychoanalytic literature (e.g., Kohut, 1984) is perhaps not warranted.⁶ A similar conclusion is suggested by Luborsky *et al.*'s (1988) finding that accuracy of interpretation (defined as degree of congruence between the therapist's interpretation and an independently determined measure of the

⁶Main and Goldwyn (1984) write that "thus, we are condemned to repeat what we cannot remember . . ." (p. 214), a conclusion that is, of course, a restatement of Freud's (1914, 1920) claim regarding the relationship between repression and failure to remember on the one hand and repetition on the other. It is ironic that impressive evidence for Freud's claim comes not from studies specifically designed to test that hypothesis, but from research on intergenerational transmission of attachment patterns.

patient's CCRT) is positively related to therapeutic outcome insofar as accuracy of interpretation is likely to facilitate insight.

The Role of the Therapeutic Relationship

Luborsky's findings, indicating a positive relationship between good outcome and the patient's experience of a helping alliance, suggest that no matter how accurate or clever the therapist's interpretations may be, if the patient does not experience the therapist as helpful and supportive and as engaged with him or her in a joint effort, change is not likely to occur.

Although I have discussed awareness and insight and the therapeutic relationship as two separate therapeutic factors, it is very likely that they are inextricably linked. An accurate interpretation, properly timed and presented with tact and concern, may not only facilitate awareness and insight, but may also convey the therapist's empathic understanding of the patient's inner experiences and may encourage the patient's experience of the therapist as helpful and supportive and engaged with the patient in a joint endeavor (see Eagle & Wolitzky, 1989). Indeed, a good therapeutic relationship is not something one *does* as a therapist. Rather, it is *implemented* through cues, attitudes, and activities of the therapist in interaction with the patient. It is, so to speak, a *by-product* of the therapist's "normal" activities.

One can summarize the above by saying that "corrective emotional experiences" appear to be an integral and necessary aspect of therapeutic change. Alexander and French's (1946) emphasis on this factor was rejected by the psychoanalytic community largely because they suggested direct manipulation of the transference. However, the "normal" components of effective psychodynamic therapy, such as benevolent neutrality, empathic understanding, accurate interpretations, reliability, honesty, and integrity, intrinsically constitute "corrective emotional experiences." One does not have to do anything extra. Indeed, I strongly suspect that there is a paradox in which an eager and direct attempt to provide a "corrective emotional experience" is almost a guarantee that it will not be provided, while simply carrying out one's therapeutic work as honestly and carefully as one can will more likely generate "corrective emotional experiences" as an integral by-product.

REFERENCES

- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum Associates.

- Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy: Principles and application*. New York: Ronald Press.
- Beebe, B., & Lachmann, F. (1988). The contribution of mother-infant mutual influence to the origins of self and object representations. *Psychoanalytic Psychology*, 5(4), pp. 305–337.
- Blum, A., & Shadduck, C. B. (1991). Object choice revisited. *Psychoanalytic Psychology*, 8(1), pp. 59–68.
- Bowlby, J. (1969). *Attachment and loss (Vol. 1: Attachment)*. London: Hogarth Press.
- Bowlby, J. (1973). *Attachment and loss (Vol. 2: Separation)*. London: Hogarth Press.
- Bretherton, I. (1987). New perspective on attachment relations: Security, communication, and internal working models. In J. D. Osofsky (Ed.), *Handbook of infant development* (2nd ed., pp. 1061–1100). New York: John Wiley & Sons.
- Breuer, J., & Freud, S. (1893–1895). Studies in hysteria. *Standard edition* (Vol. 2, pp. 3–319). London: Hogarth Press, 1955.
- Cicchetti, D. (1989). How research on child maltreatment has informed the study of child development: Perspectives from developmental psychopathology. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 377–431). New York: Cambridge University Press.
- Dahl, H. (1972). A quantitative study of a psychoanalysis. In R. R. Holt & E. Peterfreund (Eds.), *Psychoanalysis and contemporary science* (Vol. 1, pp. 237–257). New York: The Macmillan Co.
- Davis, P. G. (1990). Repression and the inaccessibility of emotional memories. In J. L. Singer (Ed.), *Repression and dissociation*. (pp. 387–403). Chicago: University of Chicago Press.
- Dewald, P. A. (1982). Psychoanalytic perspectives on resistance. In P. Wachtel (Ed.), *Resistance: Psychodynamic and behavioral approaches* (pp. 45–68). New York: Plenum.
- Eagle, M. N. (1995). The developmental perspectives of attachment theory and psychoanalysis. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, & clinical perspectives* (pp. 123–150). Hillsdale, NJ: Analytic Press.
- Eagle, M. N. (1996). Attachment research and psychoanalytic theory. In J. M. Masling & R. F. Bornstein (Eds.), *Psychoanalytic perspectives on developmental psychology*. (pp. 105–144). Washington, DC: American Psychological Association.
- Eagle, M. N., & Wolitzky, D. L. (1989). The idea of progress in psychoanalysis. *Psychoanalysis & Contemporary Thought*, 12, 27–72.
- Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. London: Tavistock.
- Freud, S. (1914). Remembering, repeating, and working through. *Standard edition* (Vol. 12, pp. 145–156.) London: Hogarth Press, 1958.
- Freud, S. (1915). A case of paranoia running counter to the psychoanalytic theory of the disease. *Standard edition* (Vol. 14, pp. 261–272). London: Hogarth Press, 1957.
- Freud, S. (1920). Beyond the pleasure principle. *Standard edition* (Vol. 18, pp. 3–64). London: Hogarth Press, 1955.
- Freud, S. (1923). The ego and the id. *Standard edition* (Vol. 19, pp. 3–66). London: Hogarth Press, 1961.
- Freud, S. (1926). Inhibitions, symptoms, and anxiety. *Standard edition* (Vol. 20, pp. 77–175). London: Hogarth Press, 1959.
- Freud, S. (1939). Moses and monotheism. *Standard edition* (Vol. 23, pp. 3–137). London: Hogarth Press.
- Garduk, E. L., & Haggard, E. A. (1972). Immediate effects on patients of psychoanalytic interpretations. *Psychological Issues*, 7 (Monograph 28).
- Graff, H., & Luborsky, L. (1977). Long-term trends in transference and resistance: A quantitative analytic method applied to four psychoanalyses. *Journal of the American Psychoanalytic Association*, 25, 471–490.
- Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
- Greenwald, A. G. (1980). The totalitarian ego: Fabrication and revision of personal history. *American Psychologist*, 35, 603–618.
- Grunbaum, A. (1984). *The foundations of psychoanalysis: A philosophical critique*. Berkeley: University of California Press.

- Haffner, R. J. (1984). The marital repercussions of behavior therapy for agoraphobia. *Psychotherapy*, 21, 530–542.
- Jacobson, J. L., & Willie, D. R. (1986). The influence of attachment pattern on developmental changes in peer interaction from the toddler to the preschool period. *Child Development*, 57, 338–347.
- Kernberg, O. (1976). *Object relations theory and clinical psychoanalysis*. New York: Jason Aronson.
- Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.
- Loewald, H. (1980). *Papers on psychoanalysis*. New Haven, CT: Yale University Press.
- Luborsky, L., Sackeim, H., & Christoph, P. (1979). The state conducive to momentary forgetting. In J. Kihlstrom & F. Evans (Eds.), *Functional disorders of memory* (pp. 325–353). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Luborsky, L., Crits-Christoph, P., Mintz, J., & Aurbach, A. D. (1988). *Who will benefit from psychology? Predicting therapeutic outcomes*. New York: Basic Books.
- Main, M., & Goldwyn, R. (1984). Predicting rejection of her infant from mother's representation of her own experience: Implications for the abused-abusing intergenerational cycle. *Child Abuse & Neglect*, 8, 203–217.
- Main, M., Kaplan, K., & Cassidy, J. (1985). Security in infancy, childhood and adulthood. A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development* [Vol. 50 (1–2, Serial No. 209); pp. 66–104].
- Malan, D. H. (1963). *A study of brief psychotherapy*. Springfield, IL: Charles Thomas.
- Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.
- Modell, A. (1983, May 14 and 15). *Self presentation and self preservation of the self: An overview of the more recent knowledge of the narcissistic personality*. Presented to "Narcissism, Masochism, and the Sense of Guilt in Relating to the Therapeutic Process. Symposium. Sponsored by the Department of Psychiatry, Letterman General Hospital, the Mount Zion Psychotherapy Research Group, and the Extension Division of the San Francisco Psychoanalytic Institute.
- Morgan, R. W., Luborsky, L., Crits-Christoph, P., et al. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry*, 39, 397–402.
- Nelson, K., & Gruendel, J. (1981). General event representations: Basic building blocks in cognitive development. In M. E. Lamb & A. Brown (Eds.) *Advances in developmental psychology* (Vol. 1, pp. 131–158). Hillsdale, NJ: Lawrence Erlbaum.
- Pennebaker, J. W., Kiecolt-Glaser, J., & Glaser, R. (1988). Disclosure of trauma and immune functions. *Journal of Consulting and Clinical Psychology*, 56, 239–245.
- Rajcecki, D. W., Lamb, M. E. & Obmascher, P. (1978). Toward a general theory of infantile attachment: A comparative review of aspects of the social bond. *The Behavioral & Brain Sciences*, 3, 417–464.
- Rice, L. (1993). Personal communication.
- Rubinstein, B. R. (1976). On the possibility of a strictly clinical psychoanalytic theory: An essay in the philosophy of psychoanalysis. In M. M. Gill & P. S. Holzman (Eds.), *Psychology versus metapsychology: Psychoanalytic essays in memory of G. S. Klein*. New York: International Universities Press, pp. 229–264.
- Schlesinger, H. (1982). Resistance as process. In P. L. Wachtel (Ed.) *Resistance: Psychodynamic and behavioral approaches*. (pp. 25–43). New York: Plenum.
- Schuller, R., Crits-Christoph, P., & Connolly, M. B. (1991). The resistance scale: Background and psychometric properties. *Psychoanalytic Psychology*, 8, 195–211.
- Silberschatz, G., Fretter, P. B., & Curtis, J. T. (1986). How do interpretations influence the process of psychotherapy? *Journal of Consulting and Clinical Psychology*, 54, 646–652.
- Silberschatz, G., Curtis, J. T., & Nathans, S. (1989). Using the patient's plan to assess progress in psychotherapy. *Psychotherapy*, 26, 40–46.
- Speisman, J. D. (1957). *The relationship between depth of interpretation and verbal expressions*

- of resistance in psychotherapy*. Unpublished doctoral dissertation, University of Michigan, Ann Arbor.
- Sroufe, L. A. (1990). An organizational perspective of the self. In: D. Cicchetti & M. Beeghly (Eds.), *The self in transition: Infancy to childhood* (pp. 281–307). Chicago: Chicago University Press.
- Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis*, 15, 127–159.
- Strupp, H. (1973). *Psychotherapy: Clinical, research, and theoretical issues*. New York: Jason Aronson.
- Strupp, H., & Binder, J. (1984). *Psychotherapy in a new key*. New York: Basic Books.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W. W. Norton.
- Wachtel, P. L. (1982). Vicious circles: The self and the rhetoric of emerging and unfolding. *Contemporary Psychoanalysis*, 18, 259–273.
- Waelder, R. (1960). *Basic theory of psychoanalysis*. New York: International Universities Press.
- Weiss, J., Sampson, H., & the Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observations, and empirical research*. New York: Guilford Press.
- Weinberger, D. A. (1990). The construct validity of the repressive coping style. In J. L. Singer (Ed.) *Repression and dissociation* (pp. 337–386). Chicago: University of Chicago Press.
- Winnicott, D. W. (1965). *The maturational process and the facilitating environment*. New York: International University Press.